STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155662	A. BUILDING _____ B. WING _____	C 09/22/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NURSING CARE AT HARTSFIELD VILLAGE	**503 OTIS R BOWEN DR MUNSTER, IN 46321**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This visit was for the Investigation of Complaints IN00155690 and IN00155889. Complaint IN00155690- Substantiated. No deficiencies related to the allegations are cited. Complaint IN00155889- Substantiated. No deficiencies related to the allegations are cited. Survey dates: September 21 & 22, 2014 Facility number: 010758 Provider number: 155662 AIM number: 200229550 Survey Team: Janet Adams, RN-TC Census bed type: SNF: 88 SNF/NF: 21 Total: 109 Census payor type: Medicare: 39 Medicaid: 13 Other: 57 Total: 109 Sample: 14 Nursing Care at Hartsfield Village was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the Investigation of Complaints IN00155690 and IN00155889.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 000	Continued From page 1 Quality Review 09/23/14 by Lisa McColly	F 000		